

MEDICAID RENEWAL

DATE MAILED _____
DSS WORKER _____
DSS WORKER TELEPHONE _____
LOCAL AGENCY _____
ADDRESS _____
CASE NUMBER _____

Name: _____ Address: _____

Please answer questions where the block is checked. If you have any questions or need help completing the form, please call the worker listed above. Please return this form to your eligibility worker by: _____

1. ☐ Has anyone moved into or out of your household since your last eligibility determination?
☐ No ☐ Yes If yes, tell us who moved in and who moved out. _____

2. ☐ List all the income received during the past month and attach proof. Include income from sources such as wages, support, disability, retirement, Veteran's benefits, unemployment, rental property, etc.

Who Receives Income	Source	Amount
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
3. ☐ Do you have child care expenses? ☐ No ☐ Yes If yes, list child and child care costs. _____

4. ☐ If you have a child under age 19 who is working, is your child still in school? ☐ No ☐ Yes
5. ☐ Have you had a change in your health insurance since your last eligibility determination?
☐ No ☐ Yes If yes, list the company, coverage type, policy number and explain change.

6. ☐ Do you or anyone for whom your are applying have any resources such as bank accounts, vehicles, life insurance, burial arrangements and/or real property? ☐ No ☐ Yes If yes, list each resource and attach proof of the current value. Have you sold or given away any resources? ☐ No ☐ Yes If yes, explain what you sold or gave away, the date you did this, and what you received in return.

I have given true and correct information on this form to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report a change, I may be breaking the law and could be prosecuted. I authorize DSS and the Department of Medical Assistance Services (DMAS) to obtain any information needed to review my eligibility.

Signature of Recipient or Authorized Representative

Date

Relationship to Recipient

Telephone Number

Voter Registration. Check one of the following:

- () I am not registered to vote where I currently live, and I would like to register to vote here today. I certify that a voter registration form was given to me to complete. (If you would like help in filling out the voter registration, we will help you. The decision to have us help you is yours. You also have the right to complete your form in private.)
- () I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)
- () I do not want to apply to register to vote.
- () I do want to apply to register to vote. Please send me a voter registration form.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497. The phone number is (804) 786-6551.
032-03-0669-03-eng (02/05)

Medicaid Renewal

FORM NUMBER - 032-03-0669-03-eng

PURPOSE AND USE OF FORM - To report information needed to complete Medicaid renewal.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The completed form is to be retained in the case file.

INSTRUCTIONS FOR PREPARATION OF FORM – If the form is mailed, it must be sent to the recipient no later than the 11th month of eligibility. The form may be completed by an agency representative during a telephone interview and sent to the recipient for a signature or mailed to the recipient for completion. The form may also be completed by the client during an in-office interview although a face-to-face interview is not required.

Verification of income or resources will normally be required.

Upon completion of the form, the EW must evaluate the information to determine continued eligibility for Medicaid. Recipient must be sent notice of action on the renewal.

If the form is completed and returned to the agency timely and additional information and/or verification is needed, the recipient must be notified in writing of the information and/or verification needed. If the household does not complete and return the form by VaMMIS cut-off in the 12th month of eligibility, the agency must send the Advance Notice of Proposed Action to close the case effective at the end of the 12th month.